

**DATE OF REVIEW:** April 22, 2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Referral #74619 for Left L3/4 Transforaminal Injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The TMF physician reviewer is a board certified Orthopedic Surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that Referral #74619 for Left L3/4 Transforaminal Injection is not medically necessary to treat this patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a straining low back injury on xx/xx/xx. He underwent lumbar fusion surgery in 2009 and lumbar fusion exploration with hardware removal in 2010. He suffers diminished capacity for the performance of activities of daily living and lower extremity pain. Physical examination in March of 2015 reveals no reflex abnormalities, 5/5 motor strength in all myotomes, and no sensory deficits. The current request is for epidural steroid injection left L3-L4 (left L3/4 Transforaminal Injection). The request was considered and denied.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

There is no documentation in the current medical records of findings that would support the diagnosis of lumbar radiculopathy at any level. In the absence of documentation of radiculopathy, medical necessity for epidural steroid injections cannot be established. The prior denials were appropriate and should be upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)